



Department of

Human Services

Income Eligibility Applications

Child and Adult Care Food Program

Participant Eligibility



Purpose:

Determines the amount of reimbursement for each meal provided to participants

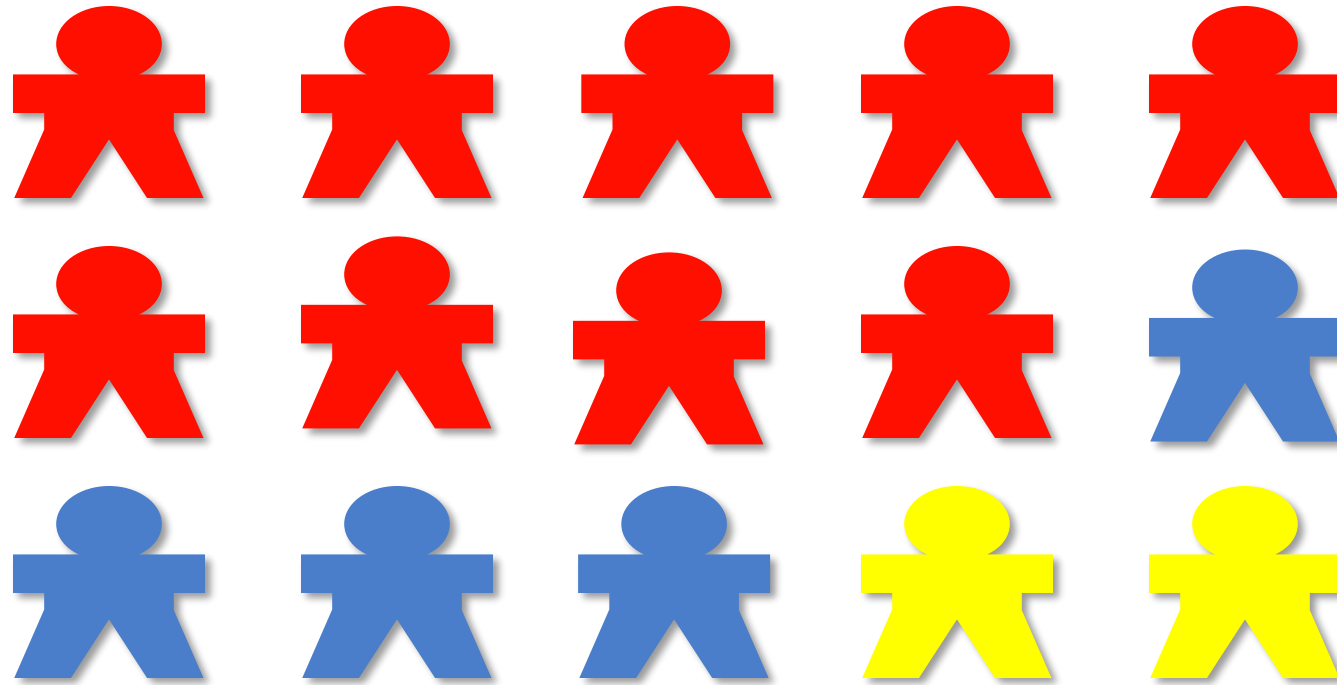
Categorization:

Free, Reduced, or Paid

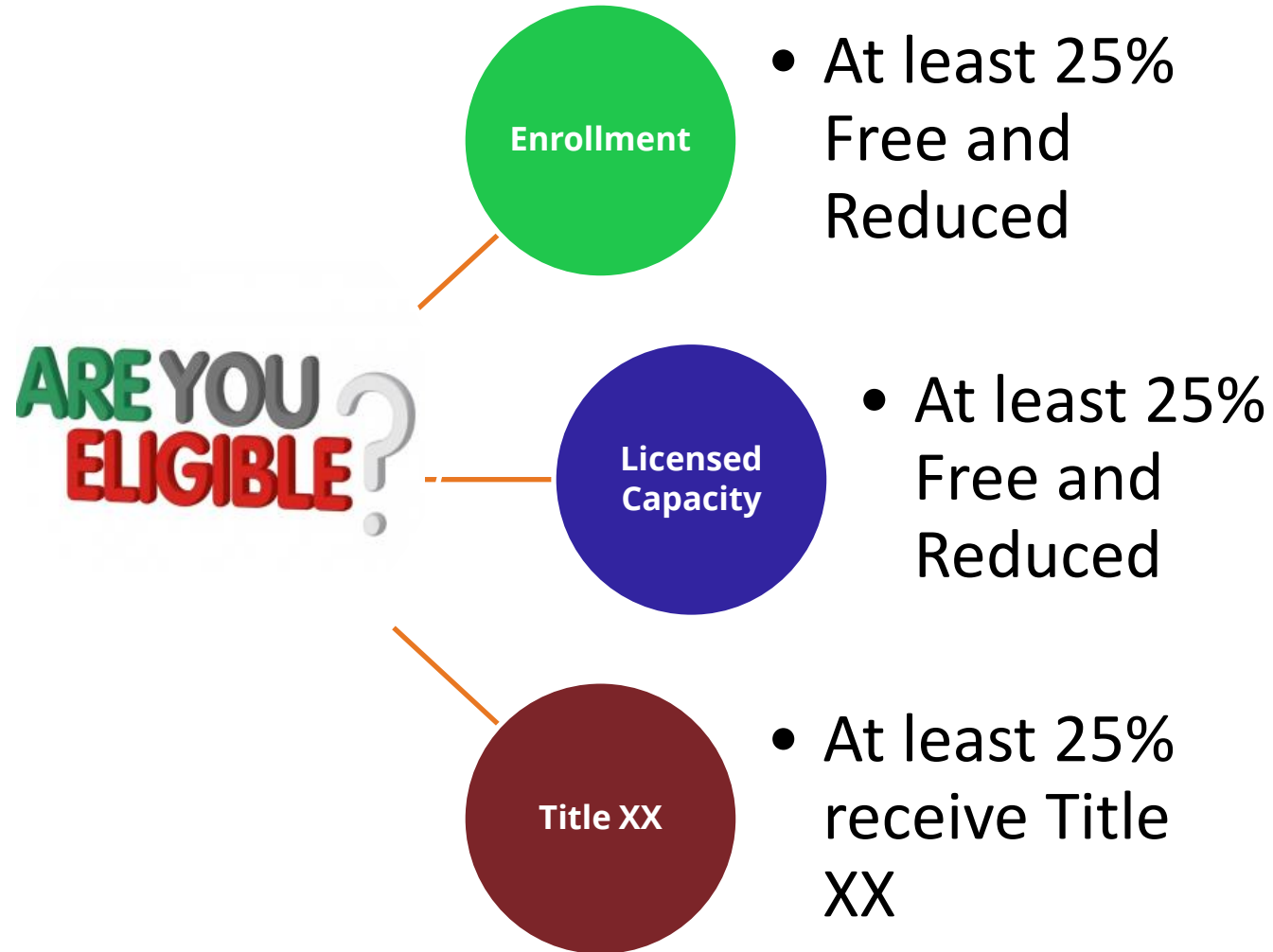
Documentation:

Not required for Head Start, ASAR, or Shelters

Purpose



Purpose (For-Profit)



Purpose (For-Profit)

Example 1

20 Participants Enrolled. . . 25% of 20= 5 participants

Example 2

License capacity is 28. . . 25% of 28= 7 participants

Example 3

5 out of 20 participants receive Title XX...25% of participants

CACFP Meal Benefit Income Eligibility (Child Care)

CACFP Meal Benefit Income Eligibility (Child Care)

Complete one application per household. Please use a pen (not a pencil).

APPLY ONLINE:

Insert URL Here

STEP 1 List ALL children in day care (if more spaces are required for additional names, attach another sheet of paper)

Definition of Household Member: "Anyone who is living with you and shares income and expenses, even if not related."

Children in Foster care and children who meet the definition of **Homeless, Migrant or Runaway** are eligible for free meals.

Child's First Name

MI

Child's Last Name

Foster Child Migrant Runaway Homeless Head Start

Check all that apply

STEP 2 Do any household members (including you) currently participate in one or more of the following assistance programs: SNAP, TANF, or FDIPIR?

IF NO > Go to STEP 3 IF YES > Write case number here and proceed to STEP 4 (do not complete STEP 3)

CASE NUMBER:

Write only one case number in this space.

STEP 3 Report Income for ALL Household Members (Skip this step if you answered "Yes" to STEP 2)

Are you unsure what income to include here? Flip the page and review the charts titled "Sources of Income" for more information.

The "Sources of Income for Children" chart will help you with the Child Income section.

The "Sources of Income for Adults" chart will help you with All Adult Household Members section.

A. Child Income

Sometimes children in the household earn or receive income. Please include the TOTAL income received by all Household Members listed in STEP 1 here.

Child Income

\$

How often?

Weekly Bi-Weekly Monthly Bi-Monthly

☐ ☐ ☐ ☐

B. All Adult Household Members (Including yourself)

List all Household Members not listed in STEP 1 (including yourself) even if they do not receive income. For each Household Member listed, if they do receive income, report total gross income (before taxes) for each source in whole dollars (no cents) only. If they do not receive income from any source, write '0'. If you enter '0' or leave any fields blank, you are certifying (promising) that there is no income to report.

Name of Adult Household Members (First and Last)

Earnings from Work

How often?

Weekly Bi-Weekly Monthly 2x Month

Welfare/Child Support/Alimony

How often?

Weekly Bi-Weekly Monthly 2x Month

Pensions/Retirement/Social Security/SSI/VA Benefits

How often?

Weekly Bi-Weekly Monthly 2x Month

Total Household Members (Children and Adults)

Last Four Digits of Social Security Number (SSN) of Primary Wage Earner or other Adult Household Member

X X X X

X X

Check if no SSN ☐

TN

Department of
Human Services

Completing the Meal Benefit Form: Step 1

Step 1

STEP 1 List ALL children in day care (if more spaces are required for additional names, attach another sheet of paper)

Definition of **Household Member**: "Anyone who is living with you and shares income and expenses, even if not related."

Children in Foster care and children who meet the definition of **Homeless, Migrant or Runaway** are eligible for free meals.

Child's First Name

MI

Child's Last Name

	Foster Child	Migrant	Runaway	Homeless	Head Start
Check all that apply	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Completing the Meal Benefit Form: Step 2

Step 2

STEP 2 Do any household members (including you) currently participate in one or more of the following assistance programs: SNAP, TANF, or FDPIR?

IF NO > Go to STEP 3 IF YES > Write case number here and proceed to STEP 4 (do not complete STEP 3)

CASE NUMBER:

Write only one case number in this space.



Completing the Meal Benefit Form: Step 3

Step 3

STEP 3 Report Income for ALL Household Members (Skip this step if you answered 'Yes' to STEP 2)

Are you unsure what income to include here? Flip the page and review the charts titled "Sources of Income" for more information.

The "Sources of Income for Children" chart will help you with the Child Income section.

The "Sources of Income for Adults" chart will help you with All Adult Household Members section.

A. Child Income

Sometimes children in the household earn or receive income. Please include the TOTAL income received by all Household Members listed in STEP 1 here.

Child Income	How often?			
	Weekly	Bi-Weekly	Monthly	Bi-Monthly
\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

B. All Adult Household Members (Including yourself)

List all Household Members not listed in STEP 1 (including yourself) even if they do not receive income. For each Household Member listed, if they do receive income, report total gross income (before taxes) for each source in whole dollars (no cents) only. If they do not receive income from any source, write '0'. If you enter '0' or leave any fields blank, you are certifying (promising) that there is no income to report.

Name of Adult Household Members (First and last)	Earnings from Work	How often?				Welfare/Child Support/Alimony	How often?				Pensions/Retirement/Social Security/SSI/VA Benefits	How often?			
		Weekly	Bi-Weekly	Monthly	2x Month		Weekly	Bi-Weekly	Monthly	2x Month		Weekly	Bi-Weekly	Monthly	2x Month
	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Total Household Members (Children and Adults)		Last Four Digits of Social Security Number (SSN) of Primary Wage Earner or other Adult Household Member	X	X	X	X	X				Check if no SSN	<input type="checkbox"/>
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Completing the Meal Benefit Form: Step 4

Step 4

STEP 4 Contact information and adult signature. MAIL COMPLETED FORM TO YOUR SCHOOL AT:

"I certify (promise) that all information on this application is true and that all income is reported. I understand that this information is given in connection with the receipt of Federal funds, and that CACFP officials may verify (check) the information. I am aware that if I purposely give false information, the participant/center may lose meal benefits, and I may be prosecuted under applicable State and Federal laws."

Print Name of Adult Signing the Form

Signature of Adult

Today's Date

Address

City

State

Zip

Phone/Email

Completing the Meal Benefit Form: Step 5

Step 5

OPTIONAL Children's Ethnic and Racial Identities (Optional)

We are required to ask for information about your children's race and ethnicity. This information is important and helps to make sure we are fully serving our community. Responding to this section is optional and does not affect your children's eligibility for receiving meals during care.

Ethnicity (check one): ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race (check one or more): ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

Completing the Meal Benefit Form: Step 6

Step 6

DO NOT FILL OUT

For official use only

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice a Month x 24, Monthly x 12

Total Income

How often?

Weekly

Bi-Weekly

Monthly

2x Month

Household size

Categorical Eligibility

Eligibility

Free

Reduced

Denied

Determining Official's Signature

Date

Confirming Official's Signature

Date

Follow-up Official's Signature

Date

Duration of Income Eligibility Determinations

- Annually update free, reduced, and paid meal eligibility information
- Information cannot be more than 12 months old
- Forms are current and valid until the last day of the month in which the form was dated one year earlier



Effective Date



Choose:

- Date parent/guardian signed
- Date sponsor official signed

Caveat:

If the date of parent signature is **not** within the same month of certification or immediately preceding the month, the effective date must be the date of certification.

SFSP 01-2015, CACFP 01-2015 *Duration of Income Eligibility Determinations: Guidance and Q&As*,
October 31, 2014

Master List

PARTICIPANT NAMES	* Racial Category Code	Ethnic Category		If applicable to program Date Enrollment Form Signed by Parent	Option selected on CRRS application Date Income Form signed by Parent OR Signed & Certified by Sponsor	Income Category			Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept
		Hispanic or Latino	Non-Hispanic or Latino			FR	RD	PD												
1 Doe, Jane	B/AA		X	7/15/2020	8/10/2020	X													E/F	
2 Jones, Joseph ("J.J.")	W	X		1/9/2020	1/15/2020		X					E/R	R	R	R	R	R	R	R	
3 Winter, Neveah	NH/PI		X	10/02/2019	10/14/2019	X			F	F	F	F	F	F	F	F	F	F	F	
4 Womack, William ("Billy")	A		X	N/A	N/A			X	P	P	P	P	P	P	P	P	W/P		E/P	
5																				
* RACIAL CATEGORY CODES:		B/AA = Black or African American				Total Free [F]			1	1	1	1	1	1	1	1	1	1	2	
AI/AN = American Indian or Alaska Native		NH/PI = Native Hawaiian or Pacific Islander				Total Reduced [R]						1	1	1	1	1	1	1	1	
A = Asian		W = White				Total Paid [P]			1	1	1	1	1	1	1	1	1		1	

Enrollment Forms

- Participant's name
- Normal days and hours of care
- Typical meals
- Signature and date
- Annual renewal
- Not required for ASAR, Emergency Shelters, OSH

ADDENDUM TO ENROLLMENT FORM FOR CHILD CARE

Name of Child Care Facility

Instructions: This Addendum may be used to meet the enrollment data requirements of the Child and Adult Care Food Program as mandated by the Interim Rule issued by the U.S. Department of Agriculture on September 1, 2004. The Addendum will be valid for one calendar year following the date of the parent's or guardian's signature.

Participant Name: _____
Last First Middle Initial

Date of Birth: _____
mm/dd/yyyy

Normal Days of Care (Circle as Appropriate):
Monday Tuesday Wednesday Thursday Friday Saturday Sunday

Normal Hours of Care during School Year: _____ to _____
to

Normal Hours of Care during Summer: _____ to _____
to

Participant Meals (Circle as Appropriate):
Breakfast AM Supplement Lunch
PM Supplement Supper Evening Supplement

Parent/Guardian Name: _____
Last First Middle Initial

Parent/Guardian Daytime Telephone Number: Area Code: ____ Number: _____

Signature of Parent/Guardian **Date of Signature**

What questions do you have?



USDA Non-discrimination Statement

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Complaint Form, (AD-3027) found online at: How to File a Complaint, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

- (1) Mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;
- (2) Fax: (202) 690-7442; or
- (3) Email: program.intake@usda.gov.

Contact Information

CACFP Main Telephone Line

(615) 313-4749

CACFP Email

cacfp.dhs@tn.gov

Tennessee Information Payment System

<https://tndhs.cnpus.com/prod/Splash.aspx>

CACFP-Department of Human Services

tn.gov/humanservices/children/dhs-nutrition-programs/child-and-adult-care-food-program.html

Resources

- CACFP Meal Benefit Income Eligibility Form

<https://www.fns.usda.gov/cacfp/english-meal-benefit-income-eligibility-form>

- Reimbursement Rates

<https://www.govinfo.gov/content/pkg/FR-2021-07-07/pdf/2021-14435.pdf>

- Federal Registry Update regarding Reimbursement Rates

<https://www.govinfo.gov/content/pkg/FR-2021-07-21/pdf/C1-2021-14435.pdf>

Thank you!

THANK
You